This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.ump.hca.wa.gov** or by calling 1-888-849-3681 (TTY 711). (Note: the Uniform Glossary can be accessed at: www.cciio.cms.gov.)

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,400** person/**$2,800** family, medical and prescription drug expenses combined and applies to the **out-of-pocket limit**. You do not pay deductible for preventive care. Family **deductible** (2 or more) must be met in full before any benefits are paid for any family members. Costs that do not count toward the **deductible** include balance-billed charges in excess of the **allowed amount.**	You must pay all the costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your policy or **plan** document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No. There are no other specific **deductibles.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$4,200** person/**$8,400** family. Family **out-of-pocket limit** (2 or more) must be met before covered services from a preferred provider are paid at 100% for the rest of the calendar year for any family member.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

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(Plan Administrator: Regence)

What is not included in the out–of–pocket limit?	**Premiums**, balance-billed charges, ancillary charges for prescription drugs, and health care services this **plan** does not cover.	Even though you pay these expenses, they don't count toward **the out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the **plan** will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.ump.hca.wa.gov** or call **1-888-849-3681** for a list of **preferred providers**.	If you use an in-network doctor or other health care **provider**, this **plan** will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. **Plans** use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this **plan** pays different kinds of **providers.**
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this **plan**.
Are there services this plan doesn't cover?	Yes.	Some of the services this **plan** doesn't cover are listed on pages 9. See your policy or **plan** document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the **plan's allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This **plan** may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an Preferred Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% co-insurance	40% co-insurance	none
	Specialist visit	15% co-insurance	40% co-insurance	none
	Other practitioner office visit	15% co-insurance	40% co-insurance	Coverage is limited to 16 visits/yr. for acupuncture, 10 visits/yr. for chiropractic care, and 16 visits/yr. for massage therapy; out-of-network massage therapy is not covered.
	Preventive care/screening/immunization	0% co-insurance	40% co-insurance	All services that receive an A or B rating by the U.S. Preventive Services Task Force, including: well baby care, women's and men's preventive screenings are covered 100%. Immunizations as recommended by the Centers for Disease and Prevention (CDC) are covered 100%. No coverage for vaccines for employment or travel.

Common Medical Event	Services You May Need	Your cost if you use an Preferred Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	15% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	15% co-insurance	40% co-insurance	Routine Computed Tomographic Colonography, MRI, upright and Coronary Artery Calcium Scoring are not covered. Imaging tests that require preauthorization are Discography and Computed Tomographic Angiography.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ump.hca.wa.gov** or 1-888-361-1611.	Generic drugs	15% co-insurance	15% co-insurance	Prescription drugs with an over-the-counter alternative are not covered; this applies to all prescription drugs in each category.
	Preferred brand drugs	15% co-insurance	15% co-insurance	
	Nonpreferred brand drugs	15% co-insurance	15% co-insurance	When you buy a brand-name drug that has a generic equivalent, you also pay the difference in cost between the brand name and the generic.
	Specialty drugs	15% co-insurance	Not covered	Limited to a 30-day supply per fill. You must get all specialty drugs from the **plan's** specialty pharmacy, Diplomat.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% co-insurance	40% co-insurance	none
	Physician/surgeon fees	15% co-insurance	40% co-insurance	none
If you need immediate medical attention	Emergency room services	15% co-insurance	15% co-insurance	none
	Emergency medical transportation	20% co-insurance	20% co-insurance	Coverage is not provided for air or water ambulance, if ground ambulance would serve the same purpose; or for ambulance services for personal or convenience purposes.
	Urgent care	15% co-insurance	40% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	40% co-insurance	Provider must notify **plan** on admission.
	Physician/surgeon fee	15% co-insurance	40% co-insurance	none

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% co-insurance	40% co-insurance	Preauthorization for outpatient mental health services may be required to determine medical necessity of the services provided; the **plan** may require your provider to submit a treatment plan. Marriage/family counseling is not covered.
	Mental/Behavioral health inpatient services	15% co-insurance	40% co-insurance	Residential treatment center admissions must be preauthorized.
	Substance use disorder outpatient services	15% co-insurance	40% co-insurance	Preauthorization for outpatient substance use disorder services may be required to determine medical necessity of the services provided; the **plan** may require your provider to submit a treatment plan.
	Substance use disorder inpatient services	15% co-insurance	40% co-insurance	Provider must notify the **plan** for inpatient detoxification and partial hospitalization. Residential treatment center admissions must be preauthorized.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	15% co-insurance	40% co-insurance	Coverage for ultrasounds during pregnancy is limited to one in week 13 or earlier and one during weeks 16-22. Additional ultrasound(s) may be covered when medically necessary.
	Delivery and all inpatient services	15% co-insurance	40% co-insurance	Circumcision is not covered.

Common Medical Event	Services You May Need	Your cost if you use an Preferred Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% co-insurance	40% co-insurance	Custodial care, maintenance care, private duty nursing or continuous care is not covered.
	Rehabilitation services	15% co-insurance	40% co-insurance	Coverage is limited to 60 days/yr. inpatient and 60 visits/yr. outpatient for all therapies combined. Inpatient admissions for rehabilitation services require preauthorization.
	Habilitation services	15% co-insurance	40% co-insurance	Coverage includes neurodevelopmental therapy and is limited to 60 days/yr. inpatient and 60 visits/yr. outpatient for all therapies combined.
	Skilled nursing care	15% co-insurance	40% co-insurance	Coverage is limited to 150 days/yr. Services must be pre-authorized.
	Durable medical equipment	15% co-insurance	40% co-insurance	Foot orthotics are not covered. Lost, stolen, or damaged durable medical equipment is not covered.
	Hospice service (including respite care)	0% co-insurance	40% co-insurance	Coverage for respite care is limited to $5,000/lifetime.

Common Medical Event	Services You May Need	Your cost if you use an Preferred Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	0% co-insurance	40% co-insurance	Eye exams for medical conditions are subject to **deductible** and **co-insurance**.
	Glasses	You pay charges over $150	You pay charges over $150	Coverage is limited to $150/2 calendar yrs.
	Dental check-up	Not covered	Not covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Circumcision
- Coronary Artery Calcium Scoring
- Cosmetic surgery
- Custodial and/or continuous care
- Dental care (Adult)
- Foot orthotics
- Immunizations for travel or employment
- Infertility treatment
- Long-term care
- Lost, stolen, or damaged durable medical equipment
- Maintenance care
- Marriage/family counseling
- MRI, upright
- Out-of-network massage therapy
- Private duty nursing
- Routine Computed Tomographic Colonography
- Weight loss programs

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine foot care for certain medical conditions

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the **plan** at 1-888-849-3681. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov.**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the **plan** at 1-888-849-3681, or the TTY line for the hearing impaired at 711. Additionally, a consumer assistance program can help you file your appeal. Contact the Washington State Consumer Assistance Program at 1-800-562-6900 or **www.insurance.wa.gov.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-888-849-3681**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-849-3681**.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-888-849-3681.**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-849-3681**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,220
- **Patient pays** $2,320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,400*
Copays	$0
Co-insurance	$920
Limits or exclusions	$0
Total	**$2,320**

Assumes single account for mother only.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $ 2,295
- **Patient pays** $1805

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$1,400*
Copays	$0
Co-insurance	$405
Limits or exclusions	$0
Total	**$1,805**

Assumes single person on the account.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health **plan**.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this **plan**.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health **plan** allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other **plans**, you'll find the same Coverage Examples. When you compare **plans**, check the "Patient Pays" box in each example. The smaller that number, the more coverage the **plan** provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket limit** costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay **out-of-pocket** expenses.

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